United States Department of Labor
Employees' Compensation Appeals Board

W.D., Appellant	)	
and	)	**Docket No. 12-451**
	)	**Issued: November 14, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Bradley, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 29, 2011 appellant filed a timely appeal from the November 15, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which granted a schedule award. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than a 25 percent impairment of his left lower extremity, for which he received a schedule award.

FACTUAL HISTORY

On March 29, 2006 appellant, then a 45-year-old letter carrier, filed an occupational disease claim alleging that the torn cartilage in his left knee was a result of performing the duties of his employment. OWCP accepted his claim for derangement of the posterior horn of the left

[1] 5 U.S.C. § 8101 *et seq.*

medial meniscus, left knee meniscus tear, chondromalacia "except patella" left, current tear of left medial meniscus and pain in the lower left leg joint.

On August 5, 2009 appellant underwent a left medial unicompartmental knee arthroplasty. He filed a schedule award claim.

In August 2010, Dr. Brett R. Levine, the Board-certified orthopedic surgeon, performed the operation, described his findings on examination. Appellant had no limp. He had no instability to varus and valgus stress or anterior and posterior drawer testing. Appellant had no extensor or flexor contracture. He had good quadriceps strength. Range of motion was 0 to 120 degrees. There was no effusion, no patellofemoral problems and no increased temperature. Appellant reported medial joint line tenderness, but overall Dr. Levine found appellant's examination to be very stable and very benign. Dr. Levine noted that appellant had neutral alignment to his lower extremity. X-rays showed well-placed and well-fixed unicompartmental knee arthroplasty with no evidence of wear or loosening.

In November 2010, Dr. Scott Sporer, a Board-certified orthopedic surgeon and an associate of Dr. Levine, described his findings on examination. Appellant had no appreciable limp and used no assistive devices. Sensory and motor examinations were grossly intact distally. Left knee range of motion showed full extension with flexion to 130 degrees. The knee was stable to varus and valgus stresses. There was no effusion. Appellant had pain to palpation along his medial joint line. There was no lateral joint line tenderness and the patellofemoral grind test was negative.

Dr. David J. Fletcher, Board-certified in occupational and preventative medicine, evaluated appellant's permanent impairment in January 2011. He related appellant's history and complaints. Appellant had an antalgic gait with decreased weight bearing on the left lower extremity. He used no assistive devices. Dr. Fletcher found atrophy over the left quadriceps and crepitus. He also found a 10-degree lack of knee extension. Current x-rays showed previous insertion of a medial joint compartment prosthesis. The lateral joint compartment was maintained with no evidence of arthritic changes.

Dr. Fletcher characterized appellant's impairment as moderate. Applying the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*,[2] he found a 20 percent impairment of the left lower extremity due to loss of extension. Dr. Fletcher found an 18 percent impairment due to gait derangement and an 8 percent impairment due to unilateral muscle atrophy. Combining all three of these impairments, he concluded that appellant had a 39 percent total impairment of the left lower extremity.

OWCP's medical adviser reviewed Dr. Fletcher's evaluation and noted that appellant had persistent subjective complaints of left knee pain that were not supported by physical examination. Using Table 16-3, page 511 of the sixth edition of the A.M.A., *Guides*,[3] he found a

[2] A.M.A., *Guides* (5th ed. 2001).

[3] *Id*. (6th ed. 2009).

25 percent impairment of the left lower extremity for a good result (good position, stable, functional) following knee arthroplasty.

On November 15, 2011 OWCP issued a schedule award for a 25 percent impairment of appellant's left lower extremity.

Appellant argues on appeal that Dr. Fletcher stands by his assessment of 39 percent. He adds that Dr. Fletcher put him through two hours of walking, climbing up and down stairs and other exercises to simulate his job, after which he noted limping and weakness in his lower extremities from atrophy. Appellant is incredulous that there is no atrophy. He states that he has pain on a daily basis. Appellant takes issue with the opinion of OWCP's medical adviser, who did not conduct a physical examination and who dismissed the pain experienced on a regular basis.

LEGAL PRECEDENT

The schedule award provision of FECA[4] and the implementing regulations[5] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. FECA, however, does not specify the manner in which the percentage of loss shall be determined. The method used in making such a determination is a matter that rests within the sound discretion of OWCP.[6]

For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by regulations as the appropriate standard for evaluating schedule losses.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

ANALYSIS

Under the applicable sixth edition of the A.M.A., *Guides*, diagnosis-based impairment is the primary method of evaluating the lower extremity. Impairment is determined first by identifying the relevant diagnosis, then by selecting the class of the impairment: no objective problem, mild problem, moderate problem, severe problem, very severe problem approaching total function loss. Each class of impairment has a default impairment rating, which can usually

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Linda R. Sherman*, 56 ECAB 127 (2004); *Danniel C. Goings*, 37 ECAB 781 (1986).

[7] *Supra* note 5; *Ronald R. Kraynak*, 53 ECAB 130 (2001).

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6.6a (January 2010); *id.*, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

be adjusted slightly using grade modifiers or nonkey factors such as functional history, physical examination or clinical studies.[9]

Chapter 16 of the A.M.A., *Guides* provides criteria for evaluating permanent impairment due to impairments of the lower extremities. Although appellant's arthroplasty was unicompartmental, the most relevant diagnosis under Table 16-3, the Knee Regional Grid, is total knee replacement, at page 511. Dr. Fletcher characterized appellant's impairment as moderate. This appears consistent with the findings of appellant's surgeon, Dr. Levine, and his associate Dr. Sporer: appellant's prosthesis was well-positioned, stable and functional. A moderate problem following knee arthroplasty has a default impairment value of 25 percent. In fact, this is the maximum impairment rating any claimant may receive for a moderate problem following knee arthroplasty. The rating cannot be adjusted higher based on grade modifiers or nonkey factors.

As OWCP's medical adviser based his recommendation of 25 percent on a review of the relevant medical evidence and on the applicable edition of the A.M.A., *Guides*, the Board finds that appellant has no more than a 25 percent impairment of his left lower extremity due to left knee arthroplasty. The Board will affirm OWCP's November 15, 2011 decision.

Appellant argues that Dr. Fletcher stands by his rating of 39 percent, but Dr. Fletcher based that rating on an outdated version of the A.M.A., *Guides*, one that was published in 2001. The sixth edition, the second printing of which was published in April 2009 and is currently in use, does not allow the combination of impairments that Dr. Fletcher performed to obtain his rating. Because he did not apply the proper edition of the A.M.A., *Guides*, Dr. Fletcher's rating does not establish appellant's impairment rating.

A rating not based on the proper edition of the A.M.A., *Guides* is of little probative value.[10] Further, the Board has held that when OWCP's medical adviser provides the only rating that conforms to the applicable edition of the A.M.A., *Guides*, that evaluation constitutes the weight of the medical evidence.[11] Even though the medical adviser in this case did not examine appellant, he was competent to analyze Dr. Fletcher's evaluation to determine if it was performed in accordance with the A.M.A., *Guides*.[12]

Appellant's case is similar to that of *S.L.*, Docket No. 12-595 (issued July 25, 2012). In *S.L.*, the attending physician improperly used the fifth edition of the A.M.A., *Guides* to evaluate the impairment of the claimant's left lower extremity. OWCP forwarded the evaluation to OWCP's medical adviser, who applied the sixth edition to the attending physician's findings. Using Table 16-3, OWCP's medical adviser found that the claimant had a moderate problem

[9] A.M.A., *Guides* 497.

[10] *James Kennedy, Jr.*, 40 ECAB 620, 627 (1989) (an opinion that is not based upon standards adopted by OWCP and approved by the Board as appropriate for evaluating schedule losses is of little probative value in determining the extent of permanent impairment).

[11] *John L. McClenic*, 48 ECAB 552 (1997).

[12] A.M.A., *Guides* 23.

following total knee replacement, which carried a default impairment value of 25 percent. Unlike the present case, the medical adviser in *S.L.* reduced the default value by 2 percent for lack of gait abnormality and 2 percent for an unremarkable physical examination, leaving the claimant with a final rating of 21 percent. The Board affirmed a schedule award based on the medical adviser's rating.

The A.M.A., *Guides* explains that the impairment ratings in the body organ system chapters, including Chapter 16, The Lower Extremities, make allowance for most of the functional losses accompanying pain.[13] Pain is most appropriately construed as a component of a medical disorder[14] and so the diagnosis-based impairment value for appellant's left knee arthroplasty accounts for the effect of pain that is typically associated with such a procedure.

As for putting appellant through two hours of exercises to simulate conditions of employment, Dr. Fletcher's findings may be relevant to the issue of appellant's disability for work or whether he should perform limited duty, but they do not reflect the permanent state of physical impairment due to the left knee arthroplasty, from which appellant appears to have had a reasonably good result with only moderate problems.[15]

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has no more than a 25 percent impairment of his left lower extremity.

[13] *Id*. at 25.

[14] *Id*. at 35.

[15] Dr. Fletcher's finding of a 10-degree extension lag differs from previously recorded observations by Dr. Levine and Dr. Sporer, both of whom found full extension. Until such a motion deficit becomes a reliably consistent finding, it may be excluded from the impairment calculation. *See id*. at 496; *see also id*. at 544: "If it is clear that a restricted range of motion has an organic basis, three measurements should be obtained and the greatest range measured should be used. If multiple evaluations exist, and there is inconsistency of a rating class between the findings of two observers or in the findings on separate occasions by the same observer, the results are considered invalid."

ORDER

IT IS HEREBY ORDERED THAT the November 15, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 14, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board